hence also a major rule under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act). As stated in section IV of this notice, we estimate that the overall effect of the changes in the Medicare Part A premium will be a cost to voluntary enrollees (sections 1818 and 1818A of the Act) of about $65 million.

C. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in the Table below, we have prepared an accounting statement showing the total aggregate cost to enrollees paying premiums in CY 2023, compared to the amount that they paid in CY 2022. This amount will be about $65 million. As stated in section IV of this notice, the CY 2023 premium of $506 is approximately 1.4 percent higher than the CY 2022 premium of $499. We estimate that approximately 730,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium. We estimate that over 90 percent of these individuals will have their Medicare Part A premium paid for by states, since they are enrolled in the QMB program. Furthermore, the CY 2023 reduced premium of $278 is approximately 1.5 percent higher than the CY 2022 premium of $274.

TABLE—ESTIMATED TRANSFERS FOR CY 2023 MEDICARE PART A PREMIUMS

Category	Transfers
Annualized Monetized Transfers.	$65 million.
From Whom to Whom	Beneficiaries to Federal Government.

D. Regulatory Flexibility Act

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration's definition of a small business (having revenues of less than $8.0 million to $41.5 million in any 1 year). Individuals and states are not included in the definition of a small entity. This annual notice announces the Medicare Part A premiums for CY 2023 and will have an impact on certain Medicare beneficiaries. As a result, we are not preparing an analysis for the RFA because the Secretary has certified that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This annual notice announces the Medicare Part A premiums for CY 2023 and will have an impact on certain Medicare beneficiaries. As a result, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has certified that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2022, that threshold is approximately $165 million. This notice would not impose a mandate that will result in the expenditure by state, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $165 million in any 1 year.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This notice will not have a substantial direct effect on state or local governments, preempt state law, or otherwise have Federalism implications.

G. Congressional Review

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on September 23, 2022.

Dated: September 26, 2022.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2022–21176 Filed 9–27–22; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8080–N]

RIN 0938–AU71

Medicare Program; CY 2023 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year (CY) 2023 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts.

DATES: The deductible and coinsurance amounts announced in this notice are effective on January 1, 2023.

FOR FURTHER INFORMATION CONTACT: Yaminee Thaker, (410) 786 7921.

SUPPLEMENTARY INFORMATION: For CY 2023, the inpatient hospital deductible will be $1,600. The daily coinsurance amounts for CY 2023 will be: $400 for the 61st through 90th day of hospitalization in a benefit period; $800 for lifetime reserve days; and $200 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary) to

determine and publish each year the amount of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year (CY).

II. Computing the Inpatient Hospital Deductible for CY 2023

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding CY, adjusted by our best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding CY, and adjusted to reflect changes in real case-mix. The adjustment to reflect real case-mix is determined on the basis of the most recent case-mix data available. The amount determined under this formula is rounded to the nearest multiple of $4 (or, if midway between two multiples of $4, to the next higher multiple of $4).

Under section 1886(b)(3)(B)(i)(XX) of the Act, the percentage increase used to update the payment rates for FY 2023 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update, reduced by an adjustment based on changes in the economy-wide productivity (the multifactor productivity (MFP) adjustment) (see section 1886(b)(3)(B)(xi)(II) of the Act). Under section 1886(b)(3)(B)(viii) of the Act, for FY 2023, the applicable percentage increase for hospitals that do not submit quality data as specified by the Secretary is reduced by one quarter of the market basket update. We are estimating that after accounting for those hospitals receiving the lower market basket update in the payment-weighted average update, the calculated deductible will not be affected, since the majority of hospitals submit quality data and receive the full market basket update. Section 1886(b)(3)(B)(ix) of the Act requires that any hospital that is not a meaningful electronic health record (EHR) user (as defined in section 1886(n)(3) of the Act) will have three-quarters of the market basket update reduced by 100 percent for FY 2017 and each subsequent FY. We are estimating that after accounting for these hospitals receiving the lower market basket update, the calculated deductible will not be affected, since the majority of hospitals are meaningful EHR users and are expected to receive the full market basket update.

Under section 1886 of the Act, the percentage increase used to update the payment rates (or target amounts, as applicable) for FY 2023 for hospitals excluded from the inpatient prospective payment system is as follows:

- The percentage increase for long term care hospitals is the market basket percentage increase reduced by the MFP adjustment (see section 1886(m)(3)(A) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments and the site-neutral payment rates (see sections 1886(m)(5) and 1886(m)(6) of the Act).
- The percentage increase for inpatient rehabilitation facilities is the market basket percentage increase reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(j)(7) of the Act).
- The percentage increase used to update the payment rate for inpatient psychiatric facilities is the market basket percentage increase reduced by the MFP adjustment (see section 1886(s)(2)(A)(i) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(s)(4) of the Act).
- The percentage increase used to update the target amounts for other types of hospitals that are excluded from the inpatient prospective payment system and that are paid on a reasonable cost basis, subject to a rate-of-increase ceiling, is the inpatient prospective payment system operating market basket percentage increase, which is described at section 1886(b)(3)(B)(ii)(VIII) of the Act and 42 CFR 413.40(c)(3). These other types of hospitals include cancer hospitals, children's hospitals, extended neoplastic disease care hospitals, and hospitals located outside the 50 states, the District of Columbia, and Puerto Rico.

The inpatient prospective payment system market basket percentage increase for FY 2023 is 4.1 percent and the MFP adjustment is 0.3 percentage point, as announced in the final rule that appeared in the **Federal Register** on August 10, 2022 entitled, ''Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation'' (87 FR 49052). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system that submit quality data and are meaningful EHR users is 3.8 percent (that is, the FY 2023 market basket update of 4.1 percent less the MFP adjustment of 0.3 percentage point). The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 3.9 percent. This average includes long term care hospitals, inpatient rehabilitation facilities, and other hospitals excluded from the inpatient prospective payment system. Weighting these percentages in accordance with payment volume, our best estimate of the payment-weighted average of the increases in the payment rates for FY 2023 is 3.81 percent.

To develop the adjustment to reflect changes in real case-mix, we first calculated an average case-mix for each hospital that reflects the relative costliness of that hospital's mix of cases compared to those of other hospitals. We then computed the change in average case-mix for hospitals paid under the Medicare inpatient prospective payment system in FY 2022 compared to FY 2021. (We excluded from this calculation hospitals whose payments are not based on the inpatient prospective payment system because their payments are based on alternate prospective payment systems or reasonable costs.) We used Medicare bills from prospective payment hospitals that we received as of July 2022. These bills represent a total of about 5.4 million Medicare discharges for FY 2022 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2022 is –0.7 percent. Based on these bills and past experience, we expect the overall FY 2022 case mix change to be − 1 percent as the year progresses and more FY 2022 data become available.

Section 1813 of the Act requires that the inpatient hospital deductible be adjusted only by that portion of the case mix change that is determined to be real. Real case-mix is that portion of case-mix that is due to changes in the mix of cases in the hospital and not due to coding optimization. COVID–19 has complicated the determination of real case-mix changes. COVID–19 cases typically have higher-weighted MS DRGs which would cause a real increase in case-mix while hospitals have experienced a reduction in lower-

weighted cases which would also cause a real increase in case-mix. The lower amount of COVID–19 cases in 2022 compared to the last several years would therefore mean a decrease in real case mix. In addition, care that was deferred in 2020 and 2021 could be more costly in 2022 causing an increase in real case-mix. Due to the uncertainty we are assuming that all of the recently observed care is not due to coding optimization and hence all of the −1 percent is real.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.81 percent, and the real case-mix adjustment factor for the deductible is −1 percent. Therefore, using the statutory formula as stated in section 1813(b) of the Act, we calculate the inpatient hospital deductible for services furnished in CY 2023 to be $1,600. This deductible amount is determined by multiplying $1,556 (the inpatient hospital deductible for CY 2022 (86 FR 64217)) by the payment-weighted average increase in the payment rates of 1.0381 multiplied by the decrease in real case-mix of 0.99, which equals $1,599.13 and is rounded to $1,600.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2023

The coinsurance amounts provided for in section 1813 of the Act are defined as fixed percentages of the inpatient hospital deductible for services furnished in the same CY. The increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in CY 2023, in accordance with the fixed percentages defined in the law, the daily coinsurance for the 61st through 90th day of hospitalization in a benefit period will be $400 (one-fourth of the inpatient hospital deductible as stated in section 1813(a)(1)(A) of the Act); the daily coinsurance for lifetime reserve days will be $800 (one-half of the inpatient hospital deductible as stated in section 1813(a)(1)(B) of the Act); and the daily coinsurance for the 21st through 100th day of extended care services in a skilled nursing facility (SNF) in a benefit period will be $200 (one-eighth of the inpatient hospital deductible as stated in section 1813(a)(3) of the Act).

IV. Cost to Medicare Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for CYs 2022 and 2023, as well as the number of each that is estimated to be paid.

TABLE 1—MEDICARE PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CYS 2022 AND 2023

Type of cost sharing	Value		Number paid (in millions)	
	2022	2023	2022	2023
Inpatient hospital deductible	$1,556	$1,600	5.41	5.90
Daily coinsurance for 61st–90th day	389	400	1.32	1.43
Daily coinsurance for lifetime reserve days	778	800	0.67	0.73
SNF coinsurance	194.50	200	28.38	27.93

The estimated total increase in costs to beneficiaries is about $1,210 million (rounded to the nearest $10 million) due to: (1) the increase in the deductible and coinsurance amounts; and (2) the increase in the number of deductibles and daily coinsurance amounts paid. We determine the increase in cost to beneficiaries by calculating the difference between the 2022 and 2023 deductible and coinsurance amounts multiplied by the estimated increase in the number of deductible and coinsurance amounts paid.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 1871 of the Act and section 553(b) of the Administrative Procedure Act (APA). Section 1871(a)(2) of the Act provides that no rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under Medicare shall take effect unless it is promulgated through notice and comment rulemaking. Unless there is a statutory exception, section 1871(b)(1) of the Act generally requires the Secretary to provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute. Similarly, under 5 U.S.C. 553(b) of the APA, the agency is required to publish a notice of proposed rulemaking in the **Federal Register** before a substantive rule takes effect. Section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act usually require a 30-day delay in effective date after issuance or publication of a rule, subject to exceptions. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the advance notice and comment requirement and the delay in effective date requirements. Sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act also provide exceptions from the notice and 60-day comment period and the 30-day delay in effective date. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act expressly authorize an agency to dispense with notice and comment rulemaking for good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest.

The annual inpatient hospital deductible and the hospital and extended care services coinsurance amounts announcement set forth in this notice does not establish or change a substantive legal standard regarding the matters enumerated by the statute or constitute a substantive rule which would be subject to the notice requirements in section 553(b) of the APA. However, to the extent that an opportunity for public notice and comment could be construed as required for this notice, we find good cause to waive this requirement.

Section 1813(b)(2) of the Act requires publication of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts between September 1 and September 15 of the year preceding the year to which they will apply. Further, the statute requires that the agency determine and publish the inpatient hospital deductible and hospital and

extended care services coinsurance amounts for each CY in accordance with the statutory formulae, and we are simply notifying the public of the changes to the deductible and coinsurance amounts for CY 2023. We have calculated the inpatient hospital deductible and hospital and extended care services coinsurance amounts as directed by the statute; the statute establishes both when the deductible and coinsurance amounts must be published and the information that the Secretary must factor into the deductible and coinsurance amounts, so we do not have any discretion in that regard. We find notice and comment procedures to be unnecessary for this notice and we find good cause to waive such procedures under section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act, if such procedures may be construed to be required at all. Through this notice, we are simply notifying the public of the updates to the inpatient hospital deductible and the hospital and extended care services coinsurance amounts, in accordance with the statute, for CY 2023. As such, we also note that even if notice and comment procedures were required for this notice, for the reasons stated above, we would find good cause to waive the delay in effective date of the notice, as additional delay would be contrary to the public interest under section 1871(e)(1)(B)(ii) of the Act. Publication of this notice is consistent with section 1813(b)(2) of the Act, and we believe that any potential delay in the effective date of the notice, if such delay were required at all, could cause unnecessary confusion both for the agency and Medicare beneficiaries.

VI. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VII. Regulatory Impact Analysis

Although this notice does not constitute a substantive rule, we nevertheless prepared this Regulatory Impact Analysis section in the interest of ensuring that the impacts of this notice are fully understood.

A. Statement of Need

This notice announces the Medicare Part A inpatient hospital deductible and associated coinsurance amounts for hospital and extended care services applicable for care provided in CY 2023, as required by section 1813 of the Act. It also responds to section 1813(b)(2) of the Act, which requires the Secretary to provide for publication of these amounts in the **Federal Register** between September 1 and September 15 of the year preceding the year to which they will apply. As this statutory provision prescribes a detailed methodology for calculating these amounts, we do not have the discretion to adopt an alternative approach on these issues.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). Although we do not consider this notice to constitute a substantive rule, based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act). As stated in section IV of this notice, we estimate that the total increase in costs to beneficiaries associated with this notice is about $1,210 million due to: (1) the increase in the deductible and coinsurance amounts; and (2) the increase in the number of deductibles and daily coinsurance amounts paid.

C. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in Table 2, we have prepared an accounting statement showing the estimated total increase in costs to beneficiaries of about $1,210 million, which is due to the increase in the deductible and coinsurance amounts, and the increase in the number of deductibles and daily coinsurance amounts paid. As stated in section IV of this notice, we determined the increase in cost to beneficiaries by calculating the difference between the 2022 and 2023 deductible and coinsurance amounts multiplied by the estimated increase in the number of deductible and coinsurance amounts paid.

TABLE 2—ESTIMATED TRANSFERS FOR CY 2023 DEDUCTIBLE AND COINSURANCE AMOUNTS

Category	Transfers
Annualized Monetized Transfers.	$1,210 million.
From Whom to Whom	Beneficiaries to Providers.

D. Regulatory Flexibility Act

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration's definition of a small business (having revenues of less than

$8.0 million to $41.5 million in any 1 year). Individuals and states are not included in the definition of a small entity. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2023 and will have an impact on the Medicare beneficiaries. As a result, we are not preparing an analysis for the RFA because the Secretary has certified that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2023 and will have an impact on the Medicare beneficiaries. As a result, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has certified that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2022, that threshold is approximately $165 million. This notice would not impose a mandate that will result in the expenditure by state, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $165 million in any 1 year.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This notice will not have a substantial direct effect on state or local governments, preempt state law, or otherwise have Federalism implications.

G. Congressional Review

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on September 23, 2022.

Dated: September 26, 2022.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2022–21180 Filed 9–27–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers CMS–10691]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by October 31, 2022.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, please access the CMS PRA website by copying and pasting the following web address into your web browser: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.*

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title:* Data Request and Attestation for PDP Sponsors; *Use:* Section 50354 of the BBA requires that the Secretary establish a process for PDP sponsors to submit a request for standardized extracts of claims data for their enrollees. In addition, Section 50354 of the BBA provides for a number of purposes and limitation for the use of the claims data and also permits the Secretary to establish other limitations necessary to protect the identity of individuals entitled to or enrolled in Medicare, and to protect the security of personal health information.

This information collection request allows a PDP sponsor to submit a request to CMS for claims data for its enrollees and to attest that it will adhere to the permitted uses and limitations on the use of the Medicare claims data that